STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155568	A. BUILDING 00 B. WING	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSPORT NURSING AND REHABILITATION	200 SHORT ST WILLIAMSPORT, IN 47993

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00104198. Complaint IN00104198 Unsubstantiated due to lack of evidence. Survey dates: February 27, 28, 29, & March 1, 2012 Facility number: 000449 Provider number: 155568 AIM Number: 100290350 Survey Team: Michelle Hosteter RN-TC Heather Lay, RN Janet Stanton, RN Rita Mullen, RN Michelle Carter, RN Census bed type: SNF/NF: 64 Total: 64 Census payor type: Medicare: 10 Medicaid: 44 Other: 10 Total: 64 Sample: 15	F0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.Provider desires that the 2567 plan of correction be considered the letter of credible allegation and requests a desk review certification of compliance on or after 03-30-2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Supplemental sample: 2 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 3/6/12 Cathy Emswiller RN			

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F0225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to report an allegation of	F0225	F225 Investigate/Report Allegations/IncidentsThe facility must not employ individuals who	03/30/2012

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	alleged abuse immediately to the facility Administrator, Director of Nursing, or Nurse Supervisor. The deficient practice impacted 2 of 2 supplemental residents [Residents #6 and #15] reviewed for alleged abuse violations from a sample of 15 residents reviewed. The facility failed to report an unusual occurrence to Indiana State Department of Health. The deficient practice impacted 1 of 1 residents reviewed for elopement from a sample of 15 residents reviewed. [Resident #31] Findings include: 1. On 2-29-12 at 9:45 A.M., the Administrator provided the facility's alleged abuse investigation for Residents #6 and #15. At that time, a "Facility Incident Reporting Form" was reviewed. The "Facility Incident Reporting Form" included, but was not limited to, "Incident Date: 12-19-11 at 2:20 P.M.... Residents Involved: [Residents #6 and #15]... Brief Description of Incident: During Resident Council meeting it was identified that [Certified Nursing Assistant #3] [CNA] had become rough with a couple of residents [Resident #6 and #15] during their shower. When questioned rough, residents replied with rushing through the shower. Immediate Action Taken:		have been found guilty of abusing, neglecting, or mistreating Residents by a court of law; or have had findings entered into the State nurse aide registry concerning abuse, neglect, mistreatment of Residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness of services as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.The facility must ensure that alleged violations involving mistreatment, neglect, or abue, including injuries of unknown source and misappropriation of Resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency)The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.The results of all investigations must be reported to the administor or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate	

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	Employee in question [CNA #3] was suspended for 3 days pending investigation, investigation initiated immediately by Executive Director [ED] and Social Service Director [SSD], Resident's interviewed with no findings, Residents [Residents #6 and #15] who initially reported that she was rough indicated during interview conducted by SSD that she was not rough, staff interviewed with no findings to support any allegation of roughness... Preventive measures taken: Abuse in-service scheduled for Thursday, December 22, 2011, staff in question was allowed to return to work based on lack of evidence... The "Facility Incident Reporting Form" was submitted to Indiana State Department of Health on 12-19-11. The facility investigation of the alleged abuse included, but was not limited to the following information: A document titled, "Monday December 19, 2011." The document included, but was not limited to, "2:30 P.M. Director of Nursing Service [DNS] received written concern report from December [2011] Resident Council meeting minutes stating couple of resident[s] stated that one of the CNAs [CNA #3] is a little rough with them while giving care... Following		action must be taken.What corrective actions will be accomplished for those Residents found to have been affected by the defecient practice?1.) Resident #6 and #15 had no negative adverse reactions and/or no negative psycho-social distress from the allegations. Both Resients identified acknowledged they had not been abused.2.) Residents have been informed to report any allegation of abuse to anyone of the staff/or the Executive Director for investigation during the Resident Council meeting 03-16-12.How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?1.) All Residents have the potential to be affected2.) No other Resident was affected or identified3.) All allegations of abuse will be investigated and reported to the ISDH within 24 hours by the Executive Director/or designeeWhat measures will be put into place to ensure that the deficient practice does not recur?1.) Activity Director was provided 1:1 in0service education by teh Executive Direcotr on 12/19/11 & 03/14/12 and reprimanded on 12/19/11 for not following facility abuse protocol2.) All staff was re-educated by the Executive Director on 03/14/12 regarding facility abuse prohibition policy (See attachment	

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	notification of the meeting minutes, [CNA #3] was walked out of the building... ED and SSD began interviewing residents from both halls a total of 12 were interviewed in addition to staff... All residents interviewed indicated that they had no episodes of any roughness with [CNA #3] as previously indicated in Resident Council... Activity Director who leads Resident Council was out of the building during the investigation... Upon return to the building the ED gave a 1:1 inservice with the Activity Director that reminded her that any allegation of abuse that has been identified in Resident Council will be brought to attention of the ED immediately following the Council meeting or after any allegations are made... Head to toe assessments were completed with no areas noted..." During daily exit conference on 2/28/12 at 3:15 P.M., Resident Council minutes regarding the above incident were requested. On 2/29/12 at 9:45 A.M., Resident Council minutes for December 2011 were received from the Administrator. The "Resident Council Minutes" dated 12/13/11, no time, included, but were not limited to, "One resident expressed to		1-1)3.) Resident Council was informed by the Executive Director on 03/16/12 to contact anyone on staff to report any allegation of abyse or if they do not feel comfortable telling anyone that they may come to the Executive DirectorHow the corrective action will be monitored to ensure the defecient practice will not recur?1.) Executive Director/or designee will randomly interview staff members about abuse policies and procedures weekly for 4 weeks using the Continuous Quality Improvement tool, then radomly interview staff members bi-weekly for 30 days then quarterly. The results of these interviews will be reviewed by the CQI committee overseen by the Executive Director. If 100% compliance is not achieved an action plan will be developed to ensure compliance. (See attachment 1-2)2.) Completion Date: 03/30/12	

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	writer that one CNA [CNA #3] is a little rough when giving her a shower. When questioned does she hurt you in any way resident stated no she seems very strong and has a very manly voice... Residents were asked to always report it if they feel threatened in any way. This resident stated I shouldn't have said anything. Resident redirected to always voice their opinions about abuse topics. Resident stated I wasn't abused..." The Activity Director was informed by Resident #6 and Resident #15 on 12/13/11, no time, during the monthly Resident Council meeting of an allegation of abuse. The Activity Director informed the DNS of the allegation 6 days later on 12/19/11. On 3/1/12 at 11:30 A.M., Resident #6's record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus type II, depression, hypertension, and congestive heart failure. A quarterly Minimum Data Set [MDS] screening assessment dated 12/1/11 included, but was not limited to, "BIMS [Brief Interview Mental Status] 14 [cognitively intact], Bathing total assist with one person..." On 3/1/12 at 11:40 A.M., Resident #15's			

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	record was reviewed. Diagnoses included, but were not limited to, anxiety, depression, and hypertension. A quarterly MDS screening assessment dated 10/2/11 included, but was not limited to, "BIMS 13 [cognitively intact], Bathing physical help with one assist..." 2. Tour of the facility was initiated on 2/27/12 at 10:45 A.M. with the DNS. Resident #31 was described as interviewable, ambulated with a rolling walker, had a wanderguard for elopement behaviors. In an interview at that time, the DNS indicated Resident #31 had attempted to elope from the facility 1-2 months ago therefore the wanderguard was placed again. She indicated Resident #31 left the facility with a friend who lived in the apartments located on the property. She indicated Resident #31 had worn a wanderguard in the past; however, his condition had improved since that time with no elopement behaviors. On 2/28/12 at 1:25 P.M., Resident #31's record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, diabetes mellitus, and atrial fibrillation.			

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	An "Elopement Risk Assessment" dated 4/16/11 included, but was not limited to, "Resident has a history of eloping from home or facility... yes, Resident experiences increased confusion at certain times of the day... yes, Resident walks/paces about the facility and is often seen trying to open exit doors... yes, Resident has been assigned a security bracelet [wanderguard]... yes..." A "Physician's Orders" dated 8/11/11, no time, included, but was not limited to, "May discontinue wanderguard... Care plan update, no exit seeking behavior..." A "Social Service Progress Notes" dated 11/4/11, no time, included, but was not limited to, "Resident quarterly Minimum Data Set [MDS] completed... Brief Mental Status [BIMS] is 12 [moderately cognitively impaired]... Resident scored higher on this BIMS than in the past... Resident states he gets fidgety and restless due to being out working instead of sitting in the facility... Resident is active and social..." A "Progress Notes" dated 12/9/11 at 6:35 P.M., included, but was not limited to, "Resident alert and oriented to person, place, and time... Does have memory deficit..			

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	A "Progress Notes" dated 1/22/12 at 2:02 P.M., included, but was not limited to, "Wanderguard working and placement verified, no exit seeking noted..." A "Physician's Orders" dated 1/22/12, no time, included, but was not limited to, "Wanderguard placement due to new elopement assess [sic] and triggers... Also history of elopement attempts... Care plan update, potential for exit seeking..." A "Progress Notes" dated 1/23/12 at 2:23 P.M., included, but was not limited to, "Resident's annual MDS completed at this time... BIMS 8 [cognitively moderately impaired]... Resident's care plans focus on full code, long term, and elopement risk..." A "Observation Report" dated 1/23/12 at 9:35 A.M., included, but was not limited to, "Elopement Risk Assessment: Resident has history of eloping from home or facility... yes, Resident experiences increased confusion at certain times of the day... yes, Resident walks/paces about the facility and is often seen trying to open exit doors... yes, Has the resident been assigned a security bracelet... yes..." In an interview 2/29/12 at 11:15 A.M.,			

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	with the Administrator regarding Resident #31's elopement attempt on 1/22/12, he indicated Resident #31 was let out of the facility by a housekeeper who no longer works for the facility. The Administrator indicated Resident #31 was with a friend who lives in the apartments located on the facility property. He indicated Resident #31 walked the friend home and the housekeeper let him out of the facility, informed the nurse working who then informed the Administrator. The Administrator indicated immediately after he was notified of Resident #31 leaving the building, he went to the apartment and walked him back to the facility. The Administrator indicated the housekeeper was informed not to let residents out of the building unless authorized by the nursing staff or Administrator. The Administrator indicated he did not report the incident to Indiana State Department of Health because it was not an elopement; however, Resident #31 was placed with a wanderguard after the incident. The facility failed to report the unusual occurrence/elopement of Resident #31. 3. During daily exit conference on 2/28/12 at 3:15 A.M., the facility policy on "Abuse Prohibition, Reporting, and Investigation" and "Resident Leave of			

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	Absence" was requested. The facility "Abuse Prohibition, Reporting, and Investigation Policy and Procedure" dated 2/10 was received on 2/29/12 at 9:45 A.M. The policy and procedure included, but was not limited to: "Policy and Procedure: All abuse allegations/abuse must be reported to the Executive Director immediately, and to resident's representative within 24 hours of the report. Failure to report will result in disciplinary action, up to and including immediate termination... It is the responsibility of every employee of American Senior Communities to not only report abuse situations, but also suspicion and unusual observations and circumstances to his/her immediate supervisor... The ED/designee will report all unusual occurrences, which include abuse, within 24 hours of discovery, to the Long Term Care Division of Indiana State Department of Health. Upon completion of the investigation, which must occur within 5 working days of the reporting of an occurrence, a report of the investigation must be forwarded to the Long Term Care Division of Health. Copies of the completed investigation must also be sent to Adult Protective Services, Ombudsman, and Director of			

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	Operations... Resident Abuse - Staff member, volunteer, or visitor: Any individual who witnesses abuse or has suspicion of shall immediately notify the charge nurse on the unit, which the resident resides...Definition of unusual occurrences/event: An unusual occurrence/event is defined as any happening not consistent with routine operation of the nursing facility, which may have caused of may have the potential for causing injury to residents, visitors, or loss or damage of property... All unusual occurrences are to be viewed as serious for purposes of investigation and follow-up..." The facility "Leave of Absence" policy and procedure dated 3/10 was received on 2/29/12 at 1:40 P.M. The policy and procedure included, but was not limited to, "Policy: It is the policy of this facility that continuity of care during resident Leave of Absence will be provided. Leave of absence requires a physician's order... Nursing will obtain a physician's order for the resident to go out on pass or leave of absence with responsible party... The resident/family/Power of Attorney need to sign resident in and out of the facility on the Leave of Absence form... The licensed nurse will document resident status upon			

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	leave from the facility and upon return from leave..." 3.1-28(2)(c)			

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F0226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure their Abuse Prohibition Policies were followed related to reporting alleged abuse immediately to the Administrator, Director of Nursing, or Nurse Supervisor and failed to report an unusual occurrence to the State agencies. The deficient practice impacted 2 of 2 supplemental residents [Resident #6 and #15] reviewed for alleged abuse violations and 1 of 1 residents [Resident #31] reviewed for elopement from a sample of 15 residents reviewed. Findings include: 1. On 2-29-12 at 9:45 A.M., the Administrator provided the facility's alleged abuse investigation for Residents #6 and #15. At that time, a "Facility Incident Reporting Form" was reviewed. The "Facility Incident Reporting Form" included, but was not limited to, "Incident Date: 12-19-11 at 2:20 P.M.... Residents Involved: [Residents #6 and #15]... Brief Description of Incident: During Resident	F0226	F226 Develop/Implement Abuse/Neglect, etc. policiesThe facility must develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of Residents and misappropriation of Resident property.What corrective actions will be accomplished for those Residents found to have been affected by the deficient practice?1.) Resident #6 and 15 had no negative adverse reactions and/or no negative psycho-social distress from the allegations. Both Residents identified acknowledged they had not been abused.2.) All allegations of abuse will be investidated and reported to the ISDH within 24 hours by the Executive Director/or designee3.) Residents was informed to express any concerns or allegations of abuse to any staff member or the Executive Director during Resident Council 03/16/12.4.) Resident #31 had no negative outcome as a result of this incidentHow other Residents having the potential to be affected by the same deficient practice will be identified and what corrective	03/30/2012

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	155568	A. BUILDING 00 B. WING	03/01/2012

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	Council meeting it was identified that [Certified Nursing Assistant #3] [CNA] had become rough with a couple of residents [Resident #6 and #15] during their shower. When questioned rough, residents replied with rushing through the shower. Immediate Action Taken: Employee in question [CNA #3] was suspended for 3 days pending investigation, investigation initiated immediately by Executive Director [ED] and Social Service Director [SSD], Resident's interviewed with no findings, Residents [Residents #6 and #15] who initially reported that she was rough indicated during interview conducted by SSD that she was not rough, staff interviewed with no findings to support any allegation of roughness... Preventive measures taken: Abuse in-service scheduled for Thursday, December 22, 2011, staff in question was allowed to return to work based on lack of evidence... The "Facility Incident Reporting Form" was submitted to Indiana State Department of Health on 12-19-11. The facility investigation of the alleged abuse included, but was not limited to the following information: A document titled, "Monday December 19, 2011." The document included, but		actions will be taken?1.) All Residents have the potential to be affected2.) No other Resident was affected3.) Resident Council was informed to express any concerns or allegations of abuse to any staff member or the Executive Director during Resident Council 03/16/12.4.) All allegations of abuse will be investigated and reported to the ISDH within 24 hours by the Executive Director/or designeeWhat measures will be put into place to ensure that the deficient practice does no recur?1.) Executive Director was re-educated by Nurse Consultant on 03/09/12 to facility policy for unusual occurrences (See attachment 2-1)2.) New elopement and BIMs assessment has been completed on 03/12/12 by the Social Services Director and the Director of Nursing Servies to reveal Resident #31 is cognitively impaired. Wanderguard bracelet remain in place.4.) Care plan phoe conference was held on 03/12/12 with Resident #31 responsivle party. Responsivle party is in agreement with order that reads "Resident may go LOA with Responsible Party." Responsible Party also agrees Residens may be signed outu by friends/families for outings.5.) All unusual occurrences that meet the facility definition of unusual occrrence will be thoroughly investigated and reported within 24-hours to	

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	was not limited to, "2:30 P.M. Director of Nursing Service [DNS] received written concern report from December [2011] Resident Council meeting minutes stating couple of resident[s] stated that one of the CNAs [CNA #3] is a little rough with them while giving care... Following notification of the meeting minutes, [CNA #3] was walked out of the building... ED and SSD began interviewing residents from both halls a total of 12 were interviewed in addition to staff... All residents interviewed indicated that they had no episodes of any roughness with [CNA #3] as previously indicated in Resident Council... Activity Director who leads Resident Council was out of the building during the investigation... Upon return to the building the ED gave a 1:1 inservice with the Activity Director that reminded her that any allegation of abuse that has been identified in Resident Council will be brought to attention of the ED immediately following the Council meeting or after any allegations are made... Head to toe assessments were completed with no areas noted..." During daily exit conference on 2/28/12 at 3:15 P.M., Resident Council minutes regarding the above incident were requested.		the ISDH by the Executive Director/or designeeHow the corrective action will be monitored to ensure the deficient practice will no recur?1.) Executive Director/or designee will randomly interview staff members about abuse policies and procedures weekly for 4 weeks using the CQI tool, then random interviews bi-weekly for 30 days then quarterly. The results of these interviews will be reviewed by the CQI committee overseen by the Executive Director. If 100% compliance is not achieved an action plan will be developed to ensure compliance. (See attachment 1-2)	

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	On 2/29/12 at 9:45 A.M., Resident Council minutes for December 2011 were received from the Administrator. The "Resident Council Minutes" dated 12/13/11, no time, included, but were not limited to, "One resident expressed to writer that one CNA [CNA #3] is a little rough when giving her a shower. When questioned does she hurt you in any way resident stated no she seems very strong and has a very manly voice... Residents were asked to always report it if they feel threatened in any way. This resident stated I shouldn't have said anything. Resident redirected to always voice their opinions about abuse topics. Resident stated I wasn't abused..." The Activity Director was informed by Resident #6 and Resident #15 on 12/13/11, no time, during the monthly Resident Council meeting of an allegation of abuse. The Activity Director informed the DNS of the allegation 6 days later on 12/19/11. On 3/1/12 at 11:30 A.M., Resident #6's record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus type II, depression, hypertension, and congestive heart failure. A quarterly Minimum Data Set [MDS]			

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	screening assessment dated 12/1/11 included, but was not limited to, "BIMS [Brief Interview Mental Status] 14 [cognitively intact], Bathing total assist with one person..." On 3/1/12 at 11:40 A.M., Resident #15's record was reviewed. Diagnoses included, but were not limited to, anxiety, depression, and hypertension. A quarterly MDS screening assessment dated 10/2/11 included, but was not limited to, "BIMS 13 [cognitively intact], Bathing physical help with one assist..." 2. Tour of the facility was initiated on 2/27/12 at 10:45 A.M. with the DNS. Resident #31 was described as interviewable, ambulated with a rolling walker, had a wanderguard for elopement behaviors. In an interview at that time, the DNS indicated Resident #31 had attempted to elope from the facility 1-2 months ago therefore the wanderguard was placed again. She indicated Resident #31 left the facility with a friend who lived in the apartments located on the property. She indicated Resident #31 had worn a wanderguard in the past; however, his condition had improved since that time with no elopement behaviors.			

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	On 2/28/12 at 1:25 P.M., Resident #31's record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, diabetes mellitus, and atrial fibrillation. An "Elopement Risk Assessment" dated 4/16/11 included, but was not limited to, "Resident has a history of eloping from home or facility... yes, Resident experiences increased confusion at certain times of the day... yes, Resident walks/paces about the facility and is often seen trying to open exit doors... yes, Resident has been assigned a security bracelet [wanderguard]... yes..." A "Physician's Orders" dated 8/11/11, no time, included, but was not limited to, "May discontinue wanderguard... Care plan update, no exit seeking behavior..." A "Social Service Progress Notes" dated 11/4/11, no time, included, but was not limited to, "Resident quarterly Minimum Data Set [MDS] completed... Brief Mental Status [BIMS] is 12 [moderately cognitively impaired]... Resident scored higher on this BIMS than in the past... Resident states he gets fidgety and restless due to being out working instead of sitting in the facility... Resident is active and			

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	social..." A "Progress Notes" dated 12/9/11 at 6:35 P.M., included, but was not limited to, "Resident alert and oriented to person, place, and time... Does have memory deficit.. A "Progress Notes" dated 1/22/12 at 2:02 P.M., included, but was not limited to, "Wanderguard working and placement verified, no exit seeking noted..." A "Physician's Orders" dated 1/22/12, no time, included, but was not limited to, "Wanderguard placement due to new elopement assess [sic] and triggers... Also history of elopement attempts... Care plan update, potential for exit seeking..." A "Progress Notes" dated 1/23/12 at 2:23 P.M., included, but was not limited to, "Resident's annual MDS completed at this time... BIMS 8 [cognitively moderately impaired]... Resident's care plans focus on full code, long term, and elopement risk..." A "Observation Report" dated 1/23/12 at 9:35 A.M., included, but was not limited to, "Elopement Risk Assessment: Resident has history of eloping from home or facility... yes, Resident experiences increased confusion at certain			

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	times of the day... yes, Resident walks/paces about the facility and is often seen trying to open exit doors... yes, Has the resident been assigned a security bracelet... yes..." In an interview 2/29/12 at 11:15 A.M., with the Administrator regarding Resident #31's elopement attempt on 1/22/12, he indicated Resident #31 was let out of the facility by a housekeeper who no longer works for the facility. The Administrator indicated Resident #31 was with a friend who lives in the apartments located on the facility property. He indicated Resident #31 walked the friend home and the housekeeper let him out of the facility, informed the nurse working who then informed the Administrator. The Administrator indicated immediately after he was notified of Resident #31 leaving the building, he went to the apartment and walked him back to the facility. The Administrator indicated the housekeeper was informed not to let residents out of the building unless authorized by the nursing staff or Administrator. The Administrator indicated he did not report the incident to Indiana State Department of Health because it was not an elopement; however, Resident #31 was placed with a wanderguard after the incident.			

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	The facility failed to report the unusual occurrence/elopement of Resident #31. 3. During daily exit conference on 2/28/12 at 3:15 A.M., the facility policy on "Abuse Prohibition, Reporting, and Investigation" and "Resident Leave of Absence" was requested. The facility "Abuse Prohibition, Reporting, and Investigation Policy and Procedure" dated 2/10 was received on 2/29/12 at 9:45 A.M. The policy and procedure included, but was not limited to: "Policy and Procedure: All abuse allegations/abuse must be reported to the Executive Director immediately, and to resident's representative within 24 hours of the report. Failure to report will result in disciplinary action, up to and including immediate termination... It is the responsibility of every employee of American Senior Communities to not only report abuse situations, but also suspicion and unusual observations and circumstances to his/her immediate supervisor... The ED/designee will report all unusual occurrences, which include abuse, within 24 hours of discovery, to the Long Term Care Division of Indiana State Department of Health. Upon completion of the investigation, which			

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	must occur within 5 working days of the reporting of an occurrence, a report of the investigation must be forwarded to the Long Term Care Division of Health. Copies of the completed investigation must also be sent to Adult Protective Services, Ombudsman, and Director of Operations... Resident Abuse - Staff member, volunteer, or visitor: Any individual who witnesses abuse or has suspicion of shall immediately notify the charge nurse on the unit, which the resident resides...Definition of unusual occurrences/event: An unusual occurrence/event is defined as any happening not consistent with routine operation of the nursing facility, which may have caused of may have the potential for causing injury to residents, visitors, or loss or damage of property... All unusual occurrences are to be viewed as serious for purposes of investigation and follow-up..." 3.1-28(a)			

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to ensure staff washed their hands during medication administration. This effected 1 of 9 resident medication preparations observed during medication pass. (Residents #27, 28 and 30) Findings include: During an observation of a medication pass, on 2/28/12 at 9:05 A.M., LPN #2 had completed the medication administration for Resident # 28, in the second bed, and was starting to leave the room, when Resident #27, in the first bed, asked for assistance adjusting the head of his bed. LPN #2 searched under Resident #27's bed sheets, found the controller and adjusted the head of the bed. LPN #2 left the room and prepared Resident #30's medications without washing her hands or using hand sanitizer. A facility policy for "Medication Administration Guidelines, dated 7/2011, received from the Director of Nursing, on	F0282	F282 Services by qualified persons/per care planThe services provided or arranged by the facility must be provided by qualified persons in accordance with each Resident's written plan of careWhat corrective actions will be accomplished for those Residents found to have been affected by defecient practice?1.) Residents #27, 28 and 30 were not harmed2.) Staff are now hand washing cirrectly during medication pass**How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**1.) All Residents have the potential to be affected2.) No other Residents were identified to have been affected3.) All Licensed and non-licensed staff was re-educated on 03/14/12 by the Executive Director to facility hand washing policy and procedures. (See attachment 3-1)What measures will be put into place to ensure that the deficient practice does not recur?1.) LPN#2 was immediately counseled by the DNS on 02/28/12 and provided a verbal 1:1 re-education the same date2.) DNS or designee will	03/30/2012

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	2/29/11 at 9:00 A.M., indicated the following: "...Procedure: Medication Pass: When preparing medications the staff will follow the facility's hand washing/sanitizing policy and procedure..." A facility policy for "Hand Washing Procedure, dated 1/2011, received from the Director of Nursing on 2/29/12 at 9:00 A.M., indicated the following: "...C. 1. Decontaminating hands can refer to washing with soap and water or using alcohol gel intermittently in place of soap and water....3. Decontaminate hands before and after having direct contact with patients...D. 5. Decontaminate hands after contact with inanimate objects..." During an interview with the Director of Nursing, on 3/1/12 at 11:45 A.M., she indicate the staff would all be inserviced regarding the lack of hand washing while passing medications. 3.1-35(g)(2)		complete random audits of all Licensed nursing personnel weekly to observe hand washing during medication administration on all shifts for 30 days, then bi-weekly for 30 days then quarterly to ensure appropriate hand washing occurs using the CQI skills validation checkoff. (See attachment 3-2)How the corrective action will be monitored to ensure the deficient practice will not recur?1.) All findings will be submitted and reviewed during monthly CQI meetings overseen by the Executive Director. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance2.) Completion Date: 03/30/12	

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F0371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure that 1 of 1 Dietary Cook washed her hands and used disposable gloves in the required manner, during the serving of 1 of 1 lunch meal. This deficiency had the potential to impact 63 of 64 residents who received meals from 1 of 1 facility kitchens. [Dietary Cook #1] Findings include: On 2/29/12 at 11:20 A.M., the lunch meal food service line was observed. Dietary Cook #1 was observed to have disposable gloves on while checking the temperatures of the prepared food on the service line. She was observed to touch her face/nose with one gloved finger twice; and then use the back of her gloved hand to wipe her nose. After making no attempt to remove the gloves and wash her hands, the action was called to her attention. The cook	F0371	F371 Food Procure, Store/Prepare/Serve - SanitaryThe facility must-1.) Provide food from sources approved or considered satisfactory by Federal, State or local authorities; and2.) Store, prepare, distribute and serve food under sanitary conditions**What corrective actions will be accomplished for those Residents found to have been affected by the deficient practice?**1.) No Residents were directly affected2.) Dietary staff are now completing hand washing and glove usage correctlyHow other Residents having the potential to be affected by the same deficient practice willl be identified and what corrective actions will be taken?1.) ALl Residents had the potential to be affected2.) Dietary cook was counseled and provided 1:1 re-education by Dietary Manager on 02/29/12 to re-educate dietary department hand washing & glove use**What measures will be put into place to esnure that the deficient practice does not recur?**1.) All dietary employees was	03/30/2012

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	indicated she was not aware that she had done that. She removed her gloves and threw into trash barrel. She obtained a clean pair of disposable gloves, and while holding in her left hand, reached into a covered plastic bin for a large ladle. She placed the ladle in the pan holding the day's soup entrée, and then put the gloves on, without first washing her hands. Using tongs, the cook placed slices of bread, slices of tomato, and pieces of lettuce on plates to accompany the ham salad lunch entrée. After 5-6 meal trays had been prepared and placed in a cart, the Dietary Manager expressed some concern about the holding temperatures obtained for the ham salad. She directed Cook #1 to discard the ham salad and prepare grilled cheese sandwiches for the lunch meal entrée. Cook #1 then went to the telephone on the wall, which was at the far side of the kitchen area, and picked it up to make a call. She was wearing the same gloves. On 3/1/12 at 9:53 A.M., the Administrator provided two policy/procedure forms. In an interview at that time, he indicated these policies/procedures were "specific to the dietary department."		re-educated to dietary department hand washing/glove use by the Dietary Manager on 02/29/12. (See attachment 4-1)2.) All Dietary staff was re-educated on dietary department hand washing/glove use policy and procedures by the Executive Director on 03/14/12 (See attachment 4-2)3.) DM/or designee will complete weekly dietary employee hand washing skills validation for both shifts for 30 days, then complete bi-weekly for both shifts for 30 days then quarterly until continued compliance is achieved. (See attachment 4-3)How the corrective action will be monitored to ensure the deficient practive will not recur?1.) The results of the skills validations will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance2.) Completion date: 03/30/12	

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	155568	A. BUILDING 00 B. WING	03/01/2012

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	The first policy/procedure was titled "Hand Washing," and had an original date of 02/02, with updates on 03/04 and 05/06. This policy/procedure included, but was not limited to, the following: "POLICY: Dietary staff will wash hands after touching bare human body parts other than clean hands and clean, exposed portions of arms; ... after coughing, sneezing or using a handkerchief or disposable tissue; ... after handling soiled surfaces, equipment, or utensils; during food preparation; ... before touching food or food-contact surfaces; before placing gloves on hands and after engaging in other activities that contaminate hands." The second policy/procedure was titled "Use of Gloves," and had an original date of 02/02 with updates on 05/06 and 04/11. This policy/procedure included, but was not limited to, the following: "POLICY: Gloves will be worn when handling food directly with hands to ensure that bacteria are not transferred from the food handler's hands to the product being served. PROCEDURE: 1. Hands will be washed when entering			

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	the kitchen and before putting on the gloves.... 3. Gloves are just like hands; they get soiled. Anytime a contaminate surface is touched, gloves must be changed and hands washed. * After coughing or sneezing into hands, or touching hair or face... * After handling boxes, crates or packages.... * Any time you touch a contaminated surface." The "Retail Food Establishment Sanitation Requirements, Title 410 IAC 7-24" manual, effective November 13, 2004, was reviewed on 3/2/12. The sections related to hand washing and glove use included, but was not limited to, the following: "Section 129(a) Food employees shall clean their hands and exposed portions of their arms as specified under section 128 of this rule immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service and single use articles and the following: (1) After touching bare human body parts other than clean hands and clean, exposed portions of arms.... (4) After coughing, sneezing, or using a handkerchief or			

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	disposable tissue.... (6) After handling soiled surfaces, equipment, or utensils.... (9) Before touching food or food-contact surfaces. (10) Before placing gloves on hands...." "Section 246(a) If used, single-use gloves shall be: (1) used for only one (1) task, such as working with ready-to-eat food or with raw animal food; (2) used for no other purpose; and (3) discarded when: (A) damaged or soiled; or (B) interruptions occur in the operation...." 3.1-21(i)(2) 3.1-21(i)(3)			

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F0441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review and interview, the facility failed to ensure	F0441	F441 Infection Control, Prevent Spread, LinensThe facility must	03/30/2012

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	proper handwashing during medication administration and to initiate the two step tuberculin (TB) skin testing, for a newly admitted Resident. This impacted 1 of 9 Residents observed during medication pass and 1 of 15 Residents reviewed for TB testing in a sample of 15. (Residents # 27, 28, 30 and 46) Findings include: 1. During an observation of a medication pass, on 2/28/12 at 9:05 A.M., LPN #2 had completed the medication administration for Resident # 28, in the second bed, and was starting to leave the room, when Resident #27, in the first bed, asked for assistance adjusting the head of his bed. LPN #2 searched under the Resident #27's bed sheets, found the controller and adjusted the head of the bed. LPN #2 left the room and prepared Resident #30's medications with out washing her hands or using hand sanitizer. A facility policy for "Medication Administration Guidelines, dated 7/2011, received from the Director of Nursing, on 2/29/11 at 9:00 A.M., indicated the following: "...Procedure: Medication Pass: When preparing medications the staff will		establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of diseases and infection.(a.) Infection Control ProgramThe facility must establish and infection control program under which it -(1.) Investigates, controls, and prevents infections in the facility;(2.) Decide what procedures, such as isolation, should be applied to an individual Resident; and (3.) Maintain a record of incidents and corrective actions related to infections(b.) Preventing Spread of Infection(1.) When the infection control program determnines that a Resident needs isolation to prevent the spread of infection, the facility must isolate the Resident(2.) The facility must prohibit employees with communicable disease or infected skin lesions from direct contact with Residents or their food, if direct contact will transmit the disease(3.) The facility must require staff to wah their hands after each direct Resident contact for which hand washing is indicated by accepted professional practice(c.) LinersPersonnel must handle, store, process and transport linens so as to prevent the spread of infectionWhat corrective actions will be accomplished for	

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	follow the facility's hand washing/sanitizing policy and procedure..." A facility policy for "Hand Washing Procedure, dated 1/2011, received from the Director of Nursing on 2/29/12 at 9:00 A.M., indicated the following: "...C. 1. Decontaminating hands can refer to washing with soap and water or using alcohol gel intermittently in place of soap and water....3. Decontaminate hands before and after having direct contact with patients...D. 5. Decontaminate hands after contact with inanimate objects..." During an interview with the Director of Nursing, on 3/1/12 at 11:45 A.M., she indicate the staff would all be inserviced regarding the lack of hand washing while passing medications. 2. The clinical record of Resident #46 was reviewed on 2/27/12 at 1:30 P.M. He was admitted to the facility on 11/21/11. Diagnoses included, but were not limited to, dementia, end stage renal disease and diabetes. A review of the "Resident Immunization and Health History Form" indicated a TB skin test was done on 2/6/12 and read on		those Residents found to have been affected by the deficient practice?1.) Residents #27, 28 and 30 were not harmed2.) Staff are now hand washing correctly during medication pass**How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**1.) All Residents have the potential to be affected2.) No other Residents were identified to have been affected3.) All Licensed and non-licensed staff was re-educated on 03/14/12 by the ED to facility hand washing policy and procedures (See attachment 3-1)What measures will be put into place to ensure that the deficient practice does not recur?1.) LPN#2 was immediately counseled by the DNS on 02/28/12 and provided a verbal 1:1 re-education the same date2.) DNS or designee will complete random audits of all Licensed nursing personnel weekly to observe hand washing during medication administration on all shifts for 30 days, then bi-weekly for 30 days then quarterly to ensure appropriate hand washing occursHow the corrective action will be monitored to ensure the deficient practice will not recur?1.) All findings will be submitted and reviewed during montly CQI meetings overseen by the ED. If the threshold of 95% is not achieved an action plan will	

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	2/8/12. A second TB skin test was done on 2/22/12 and read on 2/24/12. Both results were 0 millimeters. During an interview with the Expositive Director, on 3/1/12 at 3:00 P.M., he indicated the two step Tb skin testing was not done when Resident #46 was admitted to the facility. 3.1-18(e) 3.1-18(l)		be developed to ensure compliance2.) Completion date: 03/30/12What corrective actions will be accomplished for those Residents found to have been affected by the deficient practice?1.) Resident #46 had no negative adverse reactions2.) Resident #46 was administered the 2nd step PPD with negative resultsHow other Residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?1.) All Residents have the potential to be affected2.) A 100% chart review was completed on 03/14/12 by the DNS and ADNS to ensure no other Residents were affected, no other Residents were identifiedWhat measures will be put into place to ensure that the deficient practice does not recur?1.) DNS and ADNS were re-edcuated to facility infection control/TB policy by the DNS Specialist on 03/09/122.) All Licensed nursing staff was re-educated to facility policy and procedure on tuberculosis3.) ADNS/or designee will complete TB audits on all new admission coming into the facility dailiy for 30 days, weekly for 30 days, then bi-weekly for 30 days to ensure 100% compliance is achieved.How the corrective action will be monitored to ensure the deficient practice will no recur?1.) Audits will be submitted for review to the CQI committee	

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			overseen by the ED. If the threshold of 100% is not achieved a plan of action will be developed to ensure compliance.2.) Completion date: 03/30/12	